1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8641

CERTIFICATE OF DEATH

Reg. Dist. No. 08635

1. PLACE OF DEATH
a. COUNTY: Allegany
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Home Frostburg, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: Box 286
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Mable Middle West Last Arnold

4. DATE OF DEATH: Month Aug. Day 15, Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 10, 1885

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months 4 Days 5
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Keeper

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): New Creek, W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Zachariah Arnold

14. MOTHER'S MAIDEN NAME: Anna Saylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Nancy Parker Arnold (Sister) Address: Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 6 mos
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): arterio - sclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-1, 1961, to 8-15, 1961, that I last saw the deceased alive on 8-14, 1961, and that death occurred at 8 a. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: H.C. Diehl M.D.
ADDRESS (Street, city or town, state): Frostburg, Maryland
DATE SIGNED: 8/16/61

PHYSICIAN'S NAME (Type): Harold C. Diehl M.D. 39 W. Main St. Frostburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-18-61
22c. NAME OF CEMETERY OR CREMATORY: Dulling Cemetery
22d. LOCATION (City, town, or county) (State): Keyser, W.Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Thomas L. Smith Jr. ADDRESS: Keyser W.Va.

24a. REC'D BY REGISTRAR DATE AUG 18 '61

24b. REGISTRAR'S SIGNATURE: Charles E. Kenny

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8642 Item 9 Film 0290 9/8/61 mn

CERTIFICATE OF DEATH

08636

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: ALLEGANY
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 3 HRS 45 MIN.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RT. #2, CUMBERLAND
   d. STREET ADDRESS: 1 BALTIMORE PIKE
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: BABY BOY; Middle: ; Last: ATKINSON

4. DATE OF DEATH: Month: AUGUST; Day: 21; Year: 19 61

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUGUST 21, 1961

9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours 3 / Min. 45

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: HARRY W. ATKINSON

14. MOTHER'S MAIDEN NAME: LOIS V. MILLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Immediately — INTERVAL BETWEEN ONSET AND DEATH:

776X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2:00 P.M., 19....., to ....., 19....., that (I) (we) last saw the deceased alive on .....19....., and that death occured at .....M, from the causes and on the date stated above.

22a. SIGNATURE: W Royce Hodges M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-22-61

22c. PHYSICIAN'S NAME (Type): DR. W. ROYCE HODGES

22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 8-22-61

23c. NAME OF CEMETERY OR CREMATORY: Memorial Hospital

23d. LOCATION (City, town or county) (State): Cumberland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS

25a. REC'D BY REGISTRAR DATE: AUG 24 '61

25b. REGISTRAR'S SIGNATURE: Clifford L. Krauss

2660353XVD

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8643 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08637

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D. O. A. Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rt. # 4 Cumberland,
d. STREET ADDRESS: Irons Mt.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Russell — Middle: — Last: Bible
4. DATE OF DEATH: Month: August — Day: 24, — Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: April 10, 1904
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Route Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Tea Company
11. BIRTHPLACE (State or foreign country): Pendleton Co. W. Va.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Jobe Bible
14. MOTHER'S MAIDEN NAME: Clara Harmon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-10-7206
17. INFORMANT: Mrs. Pearl Bible — Address: Rt. # 4 Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

DUE TO (b): CORONARY SCLEROSIS — INTERVAL BETWEEN ONSET AND DEATH: ------

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [XX] Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M. D.
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: August 25, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/27/61
22c. NAME OF CEMETERY OR CREMATORY: Mt. Herman Cemetery
22d. LOCATION (City, town, or county) (State): Nr. Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Wayne George — ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR — DATE: AUG 28 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8644

CERTIFICATE OF DEATH

08638

Items 9 & 14 Film G293 8/30/61 jwk

1

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 3days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred H eart Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 719 Mechanic Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Helen — Middle: A. — Last: Brode

4. DATE OF DEATH: Month: August — Day: 20, — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Nov. 24, 1898

9. AGE (In years last birthday): 62 63 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: John R. Nee (D)

14. MOTHER'S MAIDEN NAME: Lucy O'Donnell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Pt's chart

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): left ventrcular failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

420.1

DUE TO (b): acute posterior myocardial infarction — 3 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): myocardial fibrosis -- coronary arteriosclerosis — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from August 17, 1961 to August 20, 1961, that (I) (we) last saw the deceased alive on August 20, 1961, and that death occured at 7:15PM, from the causes and on the date stated above.

22a. SIGNATURE: Samuel Jacobson M.D.

22b. DATE SIGNED

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): S.L. Jacobson, M.D.

22d. ADDRESS: 59 Pershing St. Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/23/61

23c. NAME OF CEMETERY OR CREMATORY: St. Peter + Paul Cem

23d. LOCATION (City, town or county) (State): Cumberland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John J. Hafer — ADDRESS: Cumb., Md.

25a. REC'D BY REGISTRAR DATE: AUG 28 '61

25b. REGISTRAR'S SIGNATURE: Charles L. Stevens

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8645 — Reg. Dist. No. 08639

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): D.O.A. Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: West Virginia — b. COUNTY: Mineral
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wiley Ford, W. Va. R5X-3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: Catherine — Last: Carlile
4. DATE OF DEATH: Month: Aug. — Day: 12 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 27, 1888
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Own Grocery Store
11. BIRTHPLACE (State or foreign country): Rio, W. Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob Baker
14. MOTHER'S MAIDEN NAME: Elizabeth ???

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Albert Browning, Address: Wiley Ford, W. Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
420.1
DUE TO (b): CORONARY SCLEROSIS — --
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I taak charge of the remains described abave, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): BENEDICT SKITARELIC?, M.D.
DATE SIGNED: August 12, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 16, 1961
22c. NAME OF CEMETERY OR CREMATORY: Rest Lawn Gardens
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: James F. Scarpelli, Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: AUG 16 '61
24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained in your file. TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with registrar prior to burial, cremation, or removal.

VS. A15ME(S) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8646 — 08640

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN: MARYLAND 12 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: 120 W. Mechanic St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles; Middle: Ruben; Last: Clark

4. DATE OF DEATH: Month: August; Day: 29th; Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 21st, 1904

9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Street Dept.

11. BIRTHPLACE (County & State, or foreign country): F'bg. Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Bessie Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 217-10-1617

17. INFORMANT: Mrs. Edna Clark, Address 120 W. Mechanic St, Frostburg, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia Hypostatic
DUE TO (b): Acute Complication - Rheumatic Fever
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
561.5
INTERVAL BETWEEN ONSET AND DEATH: 5 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Rheumatic Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MED. CAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ... 19.., to ... 19.., that (I) (we) last saw the deceased alive on .. 8/27. 1961, and that death occured at ... M, from the causes and on the date stated above.

22a. SIGNATURE: Martin M. Rothstein M.D.

ATTEND NG PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/30/61

22c. PHYSICIAN'S NAME (Type): Martin M. Rothstein, "

22d. ADDRESS: 48 Broadway, Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-1-61

23c. NAME OF CEMETERY OR CREMATORY: F'bg. Memorial Park

23d. LOCATION (City, town or county): Frostburg, (State) Md.

24 FUNERAL DIRECTOR'S SIGNATURE: J. P. Durst

ADDRESS: Frostburg, Md.

25a. REC'D BY REGISTRAR DATE: SEP 5 '61

25b. REGISTRAR'S SIGNATURE: Martha S. Hines




1

FOR STATE HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain in the space following the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9160

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08641

1. PLACE OF DEATH — 8647
   a. COUNTY: ALLEGANY
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: MARYLAND / NONE
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
   a. STATE: W. VA.
   b. COUNTY: MINERAL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 135 MAIN STREET RIDGELEY, W.VA.
   d. STREET ADDRESS: 135 MAIN STREET
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle FOREST Last CLARK

4. DATE OF DEATH: Month AUG. Day 21 Year 19 61

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 16, 1879

9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET. BOILERMAKER

10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM H. CLARK

14. MOTHER'S MAIDEN NAME: HANNAH POLAND

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv'ce): NO

16. SOCIAL SECURITY NO.: 705-09-9869

17. INFORMANT: FREDERICK T. CLARK Address: KEYSER, W.VA.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO (b): CORONARY SCLEROSIS — ---

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: August 21, 1961

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

Address (Street, city, town or county): Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: AUG. 24, 1961

22c. NAME OF CEMETERY OR CREMATORY: HILL CREST BURIAL PARK

22d. LOCATION (City, town, or country) (State): CUMBERLAND, MD.

23. FUNERAL DIRECTOR: BYRON KIGHT ADDRESS: CUMBERLAND, MD.

24a. REC'D BY REGISTRAR DATE: AUG 28 '61

24b. REGISTRAR'S SIGNATURE: Clara L. Krause




Item 18 Film 296
9-26-61 ams

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8648 08642

M

1 PLACE OF DEATH a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mt. Savage
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Edmund Middle Marvin Last Conaway
4. DATE OF DEATH: Month August Day 28, Year 1961

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: Dec. 2, 1881
9 AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months / Days / IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Fairmont, W¾Va.
12 CITIZEN OF WHAT COUNTRY? USA

I

13. FATHER'S NAME: Charles Conaway
14. MOTHER'S MAIDEN NAME: Mary Sturms

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 220-07-6748
17 INFORMANT: Albert W. Conaway, Address: Mt. Savage, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Recurrent Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
443 X
DUE TO (b): Arteriosclerotic Hypertension Cardiovascular Disease — yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Recurrent Cerebral Hemorrhages no III

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): [illegible]
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) X
20c TIME OF INJURY Hour / o m / p. m. Month / Day / Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that (I) (we) last saw the deceased alive on [illegible], 19[illegible], and that death occurred at [illegible] M, from the causes and on the date stated above.

22a SIGNATURE: [illegible] M.D
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 8/[illegible]/61
22c. PHYSICIAN'S NAME (Type): [illegible]
22d. ADDRESS: [illegible]

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Aug. 31, 1961
23c NAME OF CEMETERY OR CREMATORY: Rest Lawn Memorial Gardens
23d LOCATION (City, town, or county) (State): LaVale, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Harvey A. Leigler
ADDRESS: Hyndman, Pa.
25a. REC'D BY REGISTRAR DATE: SEP 1 '61
25b REGISTRAR'S SIGNATURE: Curtis L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Items 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59




1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8643

CERTIFICATE OF DEATH

08643

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: ALLEGANY
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIDGELEY,W.VA
   c. LENGTH OF STAY IN: MARYLAND 6 HRS.20MIN
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL MEMORIAL &WARWICK AVE.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: W.VA.
   b. COUNTY: MINERAL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIDGELEY,W.VA
   d. STREET ADDRESS: RT#1,
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First BABY BOY Middle CRIDER Last

4. **DATE OF DEATH**: Month AUGUST Day 14 Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUGUST 14,1961

9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 6 Min. 20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND,MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: CURTIS M. CRIDER

14. MOTHER'S MAIDEN NAME: BETTY J. MILLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND,MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Respiratory failure

DUE TO (b): Aspiration of meconium filled Amniotic Fluid

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 6 hrs 20 min

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8 Aug 14, 19 ..., and (I) last saw the deceased alive on 14 Aug 19 61, and that death occured at 3:10 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Leland Ransom

22b. DATE SIGNED

M.D. ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): DR. LELAND RANSOM

22d. ADDRESS: 63 GREENE ST., CUMBERLAND,MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/15/61

23c. NAME OF CEMETERY OR CREMATORY: Rest Lawn Cem

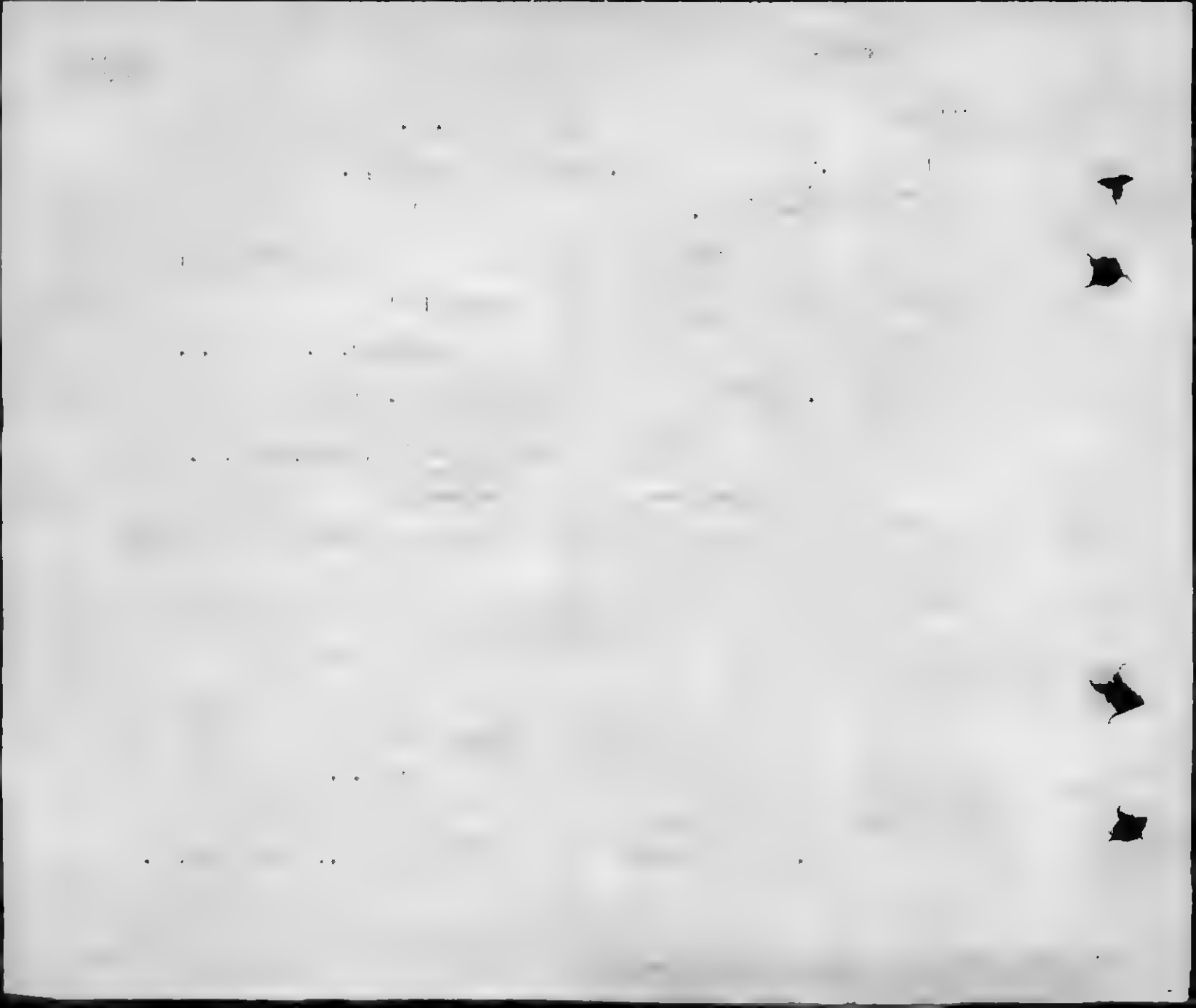
23d. LOCATION (City, town or county) (State): Cumberland Md

24. FUNERAL DIRECTOR'S SIGNATURE: James Stein Inc

ADDRESS: Cumb Md

25a. REC'D BY REG.STRAR DATE: AUG 17 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8650

CERTIFICATE OF DEATH

08644

1. **PLACE OF DEATH**
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
c. LENGTH OF STAY IN Md: MARYLAND — 2 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 121 Jamesson St.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 42 Westernport
d. STREET ADDRESS: 121 Jamesson
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Rachel Middle: S. Last: Davis

4. **DATE OF DEATH**: Month: Aug. Day: 19 Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct 5, 1895

9. AGE (In years last birthday): 65 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James W. Rohrbaugh

14. MOTHER'S MAIDEN NAME: Maggie Keplinger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Mrs. Noah Lease-Westernport, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Primary carcinoma of vulva — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

176.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 19..... to ..... 19....., that (I) (we) last saw the deceased alive on ..... 19....., and that death occured at .....M, from the causes and on the date stated above.

22a. SIGNATURE: Samuel Wolverton Jr

22b. DATE SIGNED: 8-20-61

22c. PHYSICIAN'S NAME (Type): S.H. Wolverton Jr M.D. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: Piedmont W. Va

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/21/61

23c. NAME OF CEMETERY OR CREMATORY: Keplinger Cem.

23d. LOCATION (City, town or county) (State): Maysville-Grant Ct. W.Va.

24 FUNERAL DIRECTOR'S SIGNATURE: E. L. Boal

ADDRESS: Westernport, Md.

25a. REC'D BY REGISTRAR DATE: AUG 23 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8651 Item 24, Film G294 9/15/61 iwk Item 24 File G295 9/13/61 08645

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
c. LENGTH OF STAY IN 1b: 1HR. 14MIN.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.,

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTERNPORT, MD.
d. STREET ADDRESS: 214 ROCK ST.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: BABY Middle: BOY Last: DI FABBIO

4. DATE OF DEATH: Month: 8-31-61 Day: Year: 19

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 8-30-61

9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.: 14

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: STEPHEN DI FABBIO

14. MOTHER'S MAIDEN NAME: JANICE I. BRATTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Congenital defects
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11:01 ....., 19....., to ....., 19....., that (I) (we) last saw the deceased alive on ..... 19....., and that death occured at 12:15AM from the causes and on the date stated above.

22a. SIGNATURE: Leland B Ransom M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 31 Aug 61

22c. PHYSICIAN'S NAME (Type): DR. LELAND B. RANSOM

22d. ADDRESS: 63 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/1/61

23c. NAME OF CEMETERY OR CREMATORY: St. Peters

23d. LOCATION (City, town or county) (State): Westernport, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Boal's Funeral Home

ADDRESS: Westernport, Maryland

25a. REC'D BY REGISTRAR DATE: SEP 5 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

- 211

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8652 — 08646

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Items 1 to 4 may be completed by the funeral director, page 3 should be completed by the attending physician and the papers forwarded by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: MARYLAND — 32 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: WEST VIRGINIA
b. COUNTY: HAMPSHIRE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PATTERSON CREEK
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: HENRY — Middle: J. — Last: DOHRMAN

4. **DATE OF DEATH**: Month: AUGUST — Day: 24, — Year: 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-19-1874

9. AGE (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith Helper

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (City & State, or foreign country): MARYLAND -North Branch

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: HERMAN DOHRMAN

14. MOTHER'S MAIDEN NAME: MARTHA WAGNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro vascular Accident
DUE TO (b): Generalized Arteriosclerosis
DUE TO (c): Coronary Sclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 31 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/22, 19 61 to 8/24, 19 61, that (I) (we) last saw the deceased alive on 8/24, 19 61, and that death occured at .....M, from the causes and on the date stated above.

22a. SIGNATURE: George M. Simons M.D.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. George M. Simons

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-27-1961

23c. NAME OF CEMETERY OR CREMATORY: Fort Ashby Cemetery

23d. LOCATION (City, town or county) (State): Fort Ashby, W. Va.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: AUG 31 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8653

CERTIFICATE OF DEATH

Item 8 film G292 8/15/61 jwr

08647

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 23 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 70 JANE FRAZIER VILLAGE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MYRTLE Middle M. Last DUCKWORTH

4. DATE OF DEATH: Month AUGUST Day 5 Year 19 61

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 6-10-02 1901

9. AGE (In years last birthday): 60 yrs.

If UNDER 1 YEAR: Months ____ Days ____ If UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Ownhome

11. BIRTHPLACE (City & State, or foreign country): MARYLAND Cumberland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: GEORGE W. LONG

14. MOTHER'S MAIDEN NAME: VIRGINIA LONG

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give year or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: CHART

Address: ____

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Infarction, Left — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

DUE TO (b): Thrombosis of Artery of Brain, Left — 3 weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Arteriosclerosis — 3

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Essential Hypertension & Diabetes

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour ____ a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/14, 19 61 to 8/5, 19 61, that (I) (we) last saw the deceased alive on 8/5 19 61, and that death occured at 9:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature]

22b. DATE SIGNED: 8/8/61

22c. PHYSICIAN'S NAME (Type): S. O. WEISMAN M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22d. ADDRESS: 50 Pershing Street

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-9-61

23c. NAME OF CEMETERY OR CREMATORY: Mt. Herman Cem.

23d. LOCATION (City, town or county) (State): Cumberland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: James H. Scarpelli Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: AUG 10 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Items 1 to 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Items completed by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8654

CERTIFICATE OF DEATH

08648

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Items 1-4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: When this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN this MARYLAND: 11 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 611 Woodlawn Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Samuel (Salvatore) Middle: Esposito Last:

4. **DATE OF DEATH**: Month: August Day: 11 Year: 19 61

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-23-1893

9. AGE (If over 1 year last birthday): 68 yrs
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tire Inspector

10b. KIND OF BUSINESS OR INDUSTRY: Kelly Tire Co.(Auto

11. BIRTHPLACE (County & State or foreign country): Italy Marigliano

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ralph Esposito

14. MOTHER'S MAIDEN NAME: Antoniento ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURTY NO: 214-05-9821

17. INFORMANT: Mrs. Samuel Esposito, Address: Cumberland, Md.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ANEMIA ASSOCIATED WITH CACHEXIA
DUE TO (b): PANCREATIC CARCINOMA WITH DUODENAL EROSION AND GENERALIZED ABDOMINAL METASTASIS.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 157

INTERVAL BETWEEN ONSET AND DEATH: 4 MONTHS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from APRIL 27, 1961, to AUGUST 11, 1961, that (I) (we) last saw the deceased alive on AUGUST 11, 1961, and that death occured at .....M, from the causes and on the date stated above.

22a. SIGNATURE: Richard E. Schindler, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Richard E. Schindler, MD

22d. ADDRESS: 69 GREENE ST. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-14-1961

23c. NAME OF CEMETERY OR CREMATORY: St. Patrick's Cemetery

23d. LOCATION (City, town or county) (State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli, Cumberland, Md.

ADDRESS:

25a REC'D BY REGISTRAR DATE: AUG 16 61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8655 — 08649

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: When this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 9/60

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN this place: MARYLAND 37 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institutions: Residence before admission)
a. STATE: WEST VIRGINIA
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROMNEY
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
DELPHA	M	FELLER	AUGUST	30	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
FEMALE	WHITE		NOV. 23, 1897	63 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City & State, or foreign country): W.VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM BEAN
14. MOTHER'S MAIDEN NAME: FLORENCE ELY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Uremia and cardiac failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): C V Disease
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: One month / Sev. Years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic cholecystitis + cholelithiasis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from July 23, 1961, to Aug 30, 1961, that (I) (we) last saw the deceased alive on Aug 30, 1961, and that death occured 11:00 AM from the causes and on the date stated above.

22a. SIGNATURE: Carlton Brinsfield M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): CARLTON BRINSFIELD
22d. ADDRESS: 232 BALTIMORE AVE., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county)	(State)
Burial	Sept. 2, 1961	Indian Mound Cemetery	Romney,	West Va.

24. FUNERAL DIRECTOR'S SIGNATURE: [signature] ADDRESS: Romney, W. Va.
25a. REC'D BY REGISTRAR DATE: SEP 5 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kuns

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8656 Item 9 Film 6294 9/6/61 mh 08650

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN THIS PLACE: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Midlothian
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDWARD Middle Last FIELDS

4. DATE OF DEATH: Month AUGUST Day 27 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Apr. 18, 1893

9. AGE (In years last birthday): 67 58 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal mines

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Fields

14. MOTHER'S MAIDEN NAME: Emily Mallard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO: none

17. INFORMANT: Francis Philpot, Address Rt. 1, Box 49B, Frostburg, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cor. pulmonale

DUE TO (b): Arteriosclerotic Cardiovascular Disease

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 4 days — 2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year X 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/22, 19 61, to 8/27, 19 61, that (I) (we) last saw the deceased alive on 8/27, 19 61, and that death occured at 4:10 M, from the causes and on the date stated above.

22a. SIGNATURE: Martin Rothstein M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/29/61

22c. PHYSICIAN'S NAME (Type): Martin Rothstein, M. D.

22d. ADDRESS: 48 Broadway, Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 30 '61

23c. NAME OF CEMETERY OR CREMATORY: F'bg. Memorial Park

23d. LOCATION (City, town or county) (State): Frostburg, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: J. P. Durst

ADDRESS: Frostburg, Md.

25a. REC'D BY REGISTRAR DATE: SEP 1 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kime

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed as to personal data by the informant. Pages 1 and 2 should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8657 — 08651

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: ALLEGANY
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
   c. LENGTH OF STAY IN 1b: MARYLAND / 1 DAY
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
   d. STREET ADDRESS: R.F.D.#2, UNION GROVE
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ARTHUR; Middle: JAMES; Last: FITCH
4. DATE OF DEATH: Month: AUGUST; Day: 13; Year: 1961
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7-18-1880
9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Plant Mgr.
10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.
11. BIRTHPLACE (County & State or foreign country): ENGLAND
12. CITIZEN OF WHAT COUNTRY? England
13. FATHER'S NAME: EDWARD A. FITCH
14. MOTHER'S MAIDEN NAME: FANNY BELCAM
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: MEMORIAL HOSPITAL CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a) (b), and (c))
   PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days
   DUE TO (b): Generalized arteriosclerosis ?
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   DUE TO (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Benign hypertrophy Prostate. Rt. hemorrhagic 25 June 1961
   19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. / Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12 aug, 1961 to 13 aug, 1961 that (I) (we) last saw the deceased alive on 12 aug 1961, and that death occured at 8:25AM from the causes and on the date stated above.

22a. SIGNATURE: W. Alfred Van Ormer M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 13 aug 61
22c. PHYSICIAN'S NAME (Type): DR. VAN ORMER
22d. ADDRESS: 122 So. Centre St. Cumb. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/17/61
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
23d. LOCATION (City, town or county) (State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: H. Wayne George,
ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR DATE AUG 17 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8658

CERTIFICATE OF DEATH

08652

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 78 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL - MEMORIAL & WARWICK AVENUES

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X ELLERSLIE
d. STREET ADDRESS: BOX 87
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN; Middle H.; Last GOLLICK

4. DATE OF DEATH: Month AUGUST; Day 8; Year 1961

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DECEMBER 11, 1880
9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES GOLLICK
14. MOTHER'S MAIDEN NAME: LOUISA PURKS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 3 3 2 X
DUE TO (b): Cerebral Thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Arrested Case
INTERVAL BETWEEN ONSET AND DEATH: 3 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/4/61, 19..., to 8/8/61, 19..., that (I) (we) last saw the deceased alive on 8/7/61, 19..., and that death occured at 1:15 A.M. from the causes and on the date stated above.

22a. SIGNATURE: R. J. Williams M.D.
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): DR. R. J. WILLIAMS
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS: 122 SO. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug.10,1961
23c. NAME OF CEMETERY OR CREMATORY: Hyndman Cemetery
23d. LOCATION (City, town or county) (State): Hyndman, Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: Harvey H. Leigler
ADDRESS: Hyndman, Pa.
25a. REC'D BY REGISTRAR DATE: AUG 14 '61
25b. REGISTRAR'S SIGNATURE: Cinthia L. Kuma

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8659

CERTIFICATE OF DEATH

08653

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN this MARYLAND: 57days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 509 Valley Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Orando; Middle: May; Last: Griffin

4. DATE OF DEATH: Month: August; Day: 23; Year: 19 61

5. SEX: fenale

6. COLOR OR RACE: white

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 6-7-1908

9. AGE (In years last birthday): 53 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife,

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (City & State, or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Arthur Stevens

14. MOTHER'S MAIDEN NAME: May Long

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No,

16. SOCIAL SECURITY NO.

17. INFORMANT: Miss Gladys Stevens Address: Braddock Rd. Cumb. Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Portal Cirhosis
DUE TO (b): 1.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 2 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June, 19 61 to Aug 23, 19 61 that (I) (we) last saw the deceased alive on Aug 23 19 61, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: William P Jones M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/24/61

22c. PHYSICIAN'S NAME (Type): William P Jones, md

22d. ADDRESS: 441 N Centre St, Cumberland, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/26/61

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town or county) (State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Charles L. George ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: AUG 28 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krantz

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8660

CERTIFICATE OF DEATH

08654

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 26 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 721 COLUMBIA AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
VIRGINIA	ELIZABETH	GRIMES	AUGUST	26	19 61

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
FEMALE	WHITE		MARCH 28, 1920	41 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SECRETARY	MEMORIAL HOSPITAL	NEBRASKA	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
THOMAS BOYLAND	ELLENORA FLANNAGAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.
17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma liver (metastatic)
DUE TO (b): Carcinoma Rt Breast (Adeno Ca)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schirrous Ca Left Breast 1938

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from 8-8, 19 61 to 8-26, 19 61, that (I) (we) last saw the deceased alive on ..... 19 ....., and that death occured at 2:23 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Fuller B Whitworth M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): DR. FULLER B. WHITWORTH
22d. ADDRESS: 123 BEDFORD STREET, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	8/28/61	St Patricks Cem.	Cumberland Md

24. FUNERAL DIRECTOR'S SIGNATURE: Lewis Steinbrg
ADDRESS: Cumb. Md.
25a. REC'D BY REGISTRAR DATE: AUG 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Items 1 to 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR:

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8661 **CERTIFICATE OF DEATH** 08655

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: I5 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Res'dence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: I26 Arch Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lilly; Middle: M.; Last: Harne

4. DATE OF DEATH: Month: August; Day: 24; Year: 196I

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-15-77
9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: for Sister
11. BIRTHPLACE (County & State, or foreign country): Maryland Hagerstown
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Andrew Harne (D)
14. MOTHER'S MAIDEN NAME: Lana Koontz
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Pt's Chart — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per l ne for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Uraemia — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Myocarditis & Decompensation — 12 yrs
DUE TO (c): Arteriosclerosis — 18 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 38 to Aug 24 196[illegible] that (I) (we) last saw the deceased alive Aug 24 19 61 and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Chas. Durrett M.D.
ATTEND NG PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug 25 61
22c. PHYSICIAN S NAME (Type): Dr. C. Durrett
22d. ADDRESS: 236 Virginia Ave. Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8-28-61
23c. NAME OF CEMETERY OR CREMATORY: Oakland Cemetery
23d. LOCATION (City, town or county) (State): Oakland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli Cumberland, Md.
25a. REC'D BY REGISTRAR DATE SEP 1 '61
25b. REGISTRAR'S SIGNATURE: Clarence S. Hinman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8662

CERTIFICATE OF DEATH

08656

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt. 3, Frostburg
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MARYLAND

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt. 3, Frostburg
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: H. Last: Henckel

4. DATE OF DEATH: Month: August Day: 25th, Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 13th, 1894

9. AGE (In years last birthday): 66 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Elevator Opr.

10b. KIND OF BUSINESS OR INDUSTRY: K.S. Tire Co.

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William P. Henckel

14. MOTHER'S MAIDEN NAME: Emma Logsdon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): W.W. 1

16. SOCIAL SECURITY NO.: 217-10-7231

17. INFORMANT: Mrs. May V. Henckel, Address: Rt. 3, F'bg. Md. Box 211

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis, Heart Attack — INTERVAL BETWEEN ONSET AND DEATH: 15 m

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March, 1961 to Aug. 25, 1961, that (I) (we) last saw the deceased alive on Aug. 25, 1961, and that death occured at 7:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Martin M. Rothstein M.D.

22c. PHYSICIAN'S NAME (Type): Martin M. Rothstein, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: 48 Broadway, Frostburg, Md.

22b. DATE SIGNED: 8/25/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-28-61

23c. NAME OF CEMETERY OR CREMATORY: St. Patrick's Cemetery

23d. LOCATION (City, town or county): Mt. Savage, (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: J. P. Durst

ADDRESS: Frostburg, Md.

25a. REC'D BY REGISTRAR DATE: AUG 29 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8663

CERTIFICATE OF DEATH

08657

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician as completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 11 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 317 MAGRUDER STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First LORETTA Middle — Last HINEA

4. **DATE OF DEATH**: Month 8 Day 30 Year 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2/20/72

9. AGE (In years last birthday): 89 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles E [illegible] NEWMAN

14. MOTHER'S MAIDEN NAME: [illegible] Mary V. Ogle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO

16. SOCIAL SECURITY NO.: None

17. INFORMANT: [illegible] CHART Address: [illegible]

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 4-30-0
DUE TO (b): osteoporosis of all vertebra
DUE TO (c): Generalized arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: years / years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5-15 19 61 to 5-30 19 61 that (I) (we) last saw the deceased alive on 5-30 19 61 and that death occured at ..M, from the causes and on the date stated above.

22a. SIGNATURE: B. M. Schudler M.D.

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/4/61

22c. PHYSICIAN'S NAME (Type): DR. B. SCHUDLER

22d. ADDRESS: 43 GREENE STREET

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/2/61

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cem.

23d. LOCATION (City, town or county): Hagerstown (State) Md

24. FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc.

ADDRESS: Cumb. Md.

25a. RECD. BY REGISTRAR DATE: SEP 5 61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

1

FOR STATE HEALTH DEPT.

M

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8664

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08658

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain on the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 4 to the funeral director. Page 4 should be forwarded to the State Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Allegany — MARYLAND — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland — c. LENGTH OF STAY IN 1b: 2 days — d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Allegany — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X R.D. 2, Frostburg, — d. STREET ADDRESS: — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: J. — Last: Hittle

4. DATE OF DEATH: Month: August — Day: 20th, — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Sept.30th,1885

9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. - Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mining

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas Hittle

14. MOTHER'S MAIDEN NAME: Lydia Fox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 199-14-3812

17. INFORMANT — Address: Mrs.Allen Stevens,Box 133A,RD2,F'bg.,Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): PULMONARY EMBOLISM, MASSIVE — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO (b): FRACTURE OF LEFT HIP — 4 Days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): FELL AT HOME GOING FROM KITCHEN TO BATHROOM

20c. TIME OF INJURY Hour: 3:00 p.m. — Month Day Year: Aug.16 1961

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Rt.2 — (County): FROSTBURG, — (State): ALLEG.MD.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: AUGUST 20, 1961

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

Address (Street, city, town, or county): CUMBERLAND, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-23-61

22c. NAME OF CEMETERY OR CREMATORY: F'bg.Memorial Park

22d. LOCATION (City, town, or country): Frostburg, — (State): Md.

23. FUNERAL DIRECTOR: J. P. Durst

ADDRESS: Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: AUG 23 61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kinna

VS. AISME 5M 9 60

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, stating the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8665 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08659

Items 6 & 13 Film 0292 8/16/61 ehr

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital Frostburg Md

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Pa.
b. COUNTY: Erie
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Erie
d. STREET ADDRESS: 1124 W. 25th., St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bradley; Middle: Allan; Last: Hoover

4. DATE OF DEATH: Month: aug; Day: 9; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 19 1961

9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months: 3; Days: 21 IF UNDER 24 HRS.: Hours: —; Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Erie, Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Alice Laird Hoover

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Alice Hoover, 1124 West 25th St., Erie, Address: Pa.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ASPHYXIATION
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Aspiration of Stomach Contents
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: 4-6 Min

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W O McLane M D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): W.O. McLane, M.D.

DATE SIGNED: August 9, 1961

Address (Street, city, town, or county): Frostburg, Md. (State)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-14-61

22c. NAME OF CEMETERY OR CREMATORY: Calvery Cemetery

22d. LOCATION (City, town, or country): Erie (State): Pa.

23. FUNERAL DIRECTOR: Beulah H. Montgomery ADDRESS: HAFER FUNERAL HOME 23 E. MAIN, FROSTBURG, MD.

24a. REC'D BY REGISTRAR DATE: AUG 14 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8666

CERTIFICATE OF DEATH

08660

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Allegany
   b. CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town): Cumberland
   c. LENGTH OF STAY IN this MARYLAND: 10 Days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospite , g ve street address): Sacred Heart Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince George's
   c. CITY OR TOWN (If outside corporate lim ts, write RURAL and give nearest town): Landover Hills
   d. STREET ADDRESS: 3905 74th Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First BETTY; Middle JANE; Last JENKINS

4. **DATE OF DEATH**: August 14, 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 30, 1930

9. AGE (In years last birthday): 31 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Mineral Co. W.Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry Abe

14. MOTHER'S MAIDEN NAME: Mae Maude Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT: Mr. Thomas Jenkins, Address: Landover Hills, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): X Multiple Sclerosis
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 3 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m., Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/ 7 ..., 1961, to 8/14 ..., 19 61, that (I) (we) last saw the deceased alive on 8/13 ..., 19 61, and that death occured at 8 a.m. from the causes and on the date stated above.

22a. SIGNATURE: B M Schindler

22b. DATE SIGNED: 8/14/61

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐ M.D.

22c. PHYSICIAN'S NAME (Type): B.M. Schindler

22d. ADDRESS: Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug 17, 1961

23c. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cemetery

23d. LOCATION (City, town or county) (State): Washington D C

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John J. Hafer, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: AUG 18 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

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OR ATTENDING PHYSICIAN: The law requires that the death certificate be execute n 24 hours after may be retained by the hospital or attend'ng physician.

DIRECTOR: After this certificate has been signed by the attending physician and com· l in by the funeral

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8667 — **CERTIFICATE OF DEATH** — 08661

Items 2 & 8 Film G294 9/1/61 mh

1. **PLACE OF DEATH**
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY In this place: 2 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: ~~MARYLAND~~ Pa. — b. COUNTY:
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~CATONSVILLE~~, Hyndman
   d. STREET ADDRESS: Rt. 1 ~~SPRING GROVE STATE HOSPITAL~~
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: VIRGINIA — Middle: F. — Last: JOHNS

4. DATE OF DEATH: Month: AUGUST — Day: 23 — Year: 19 61

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-25-~~1924~~ 1925

9. AGE (In years at last birthday): 36 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NURSES AIDE

10b. KIND OF BUSINESS OR INDUSTRY: HOSPITAL SPRING GROVE STATE

11. BIRTHPLACE (City, State, or foreign country): ROMNEY, W.VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ELLIS PATTERSON

14. MOTHER'S MAIDEN NAME: GERTRUDE SANDERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X Carcinomatosis Generalized (Primary) Brain Skeletal

DUE TO (b) Carcinoma Cervix

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from . . . . . 19.. to . . . . . 19....., that (I) (we) last saw the deceased alive on . . . . . 19 .. , and that death occured at 3:35 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Fuller B Whitworth M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DR. FULLER B. WHITWORTH

22d. ADDRESS: 123 BEDFORD STREET, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: Aug.26,1961

23c. NAME OF CEMETERY OR CREMATORY: Ebenezer Cemetery

23d. LOCATION (City, town or county) (State): Near Romney, Hampshire, W.Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Estle Hoffer — ADDRESS: Romney W.Va.

25a. REC'D BY REGISTRAR DATE: SEP 6 '61

25b. REGISTRAR'S SIGNATURE: Clifford L. Evans

Page 3 should be detached before the burial [illegible] Then please remove carbon papers. [illegible] and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8668 **CERTIFICATE OF DEATH** 08662

1. **PLACE OF DEATH**
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: WEST VIRGINIA — b. COUNTY: MINERAL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KEYSER
d. STREET ADDRESS: 309 N. DAVIS STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARENCE — Middle L. — Last JOHNSON

4. DATE OF DEATH: Month AUGUST — Day 12, — Year 19 61

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-23-1891

9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Textile

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: ALBERT JOHNSON

14. MOTHER'S MAIDEN NAME: ELIZABETH MARTZELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: 236-03-2418

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 155.1 Pertonitis Ruptured Gall Bladder
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9:50 P.M. 19 to ....., 19....., that (I) (we) last saw the deceased alive on .....19....., and that death occured at .....M, from the causes and on the date stated above.

22a. SIGNATURE: Fuller B Whitworth M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/13/61

22c. PHYSICIAN'S NAME (Type): DR. F. B. WHITWORTH

22d. ADDRESS: 123 BEDFORD ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 15, 1961

23c. NAME OF CEMETERY OR CREMATORY: Queens Point Cem.

23d. LOCATION (City, town or county) (State): Keyser, West Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Leo K. Chambers — ADDRESS: Keyser, W. Va.

25a. REC'D BY REGISTRAR DATE: AUG 16 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kinard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. P[illegible] may be retained by the hospital or attending physician.

TO FUN[illegible] DIRECTOR: A[illegible] this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be de[illegible]ed for use as the burial-transit permit. Then please remove cards 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8669 **CERTIFICATE OF DEATH** C8663

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be ... by the hospital or attending physician.

TO FUNERAL DIRECTOR: After ... certificate has been signed by the attending physician and comp... fully filled in ... the funeral director, page 3 should be detached ... as the burial-transit permit. Then please remove carbon pages 1 an... should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours ... death.

VR A15 (4)
ISM 9/59

1 PLACE OF DEATH a. COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE: Pennsylvania b. COUNTY: Bedford ✓
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellerslie — c. LENGTH OF STAY IN 1b: 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyndman
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print)	First: Gertrude	Middle: May	Last: Jordan	4. DATE OF DEATH	Month: Aug.	Day: 11,	Year: 1961
5. SEX: Female	6 COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	8. DATE OF BIRTH: April 20, 1890	9. AGE (In years last birthday): 71 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country): U. S. A., Penna.	12 CITIZEN OF WHAT COUNTRY?: U. S. A.				
13 FATHER'S NAME: William Tharp		14. MOTHER'S MAIDEN NAME: Jane Emerick					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17 INFORMANT: Mrs. Keith Phillips	Address: Ellerslie, Md.				

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Possible acute cerebrovascular accident — Approx. 45 min.

DUE TO (b): Chronic arteriosclerotic cardiovascular disease with hypertension

DUE TO (c): Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from approx. 1948 19___ to 8/11/61 19___, that (I) (we) last saw the deceased alive on August 3, 1961, and that death occurred at 8:30 DST from the causes and on the date stated above

22a. SIGNATURE: John A. Topper M.D.	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS ☐	22b. DATE SIGNED: 8/11/61
22c PHYSICIAN'S NAME (Type): John A. Topper, M.D.	22d. ADDRESS: Hyndman, Penna.			

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 8/14/61	23c NAME OF CEMETERY OR CREMATORY: Hyndman Cemetery	23d LOCATION (City, town or county) (State): Hyndman, Bedford Co, Pa.
24. FUNERAL DIRECTOR'S SIGNATURE: Edward F. Naugle	ADDRESS: Hyndman, Pa.	25a. REC'D BY REGISTRAR DATE: AUG 14 '61	25b. REGISTRAR'S SIGNATURE: Orlan S Kuns

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8670

CERTIFICATE OF DEATH

08664

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND,
c. LENGTH OF STAY IN 1b: 10 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL - MEMORIAL & WARWICK AVENUES

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA
b. COUNTY: MINERAL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIDGELEY,
d. STREET ADDRESS: RT. #1.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRED Middle AUSTIN Last JUDY

4. DATE OF DEATH: Month AUGUST Day 29 Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPTEMBER 13, 1896

9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): PETERSBURG, W. VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ABRAHAM JUDY

14. MOTHER'S MAIDEN NAME: BELL HISER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.

17. INFORMANT: MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 443 X — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO (b): Cerebral hemorrhage, Uremia

DUE TO (c): Hypertension, Cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. [Enter nature of injury in Part I or Part II of Item 18.]

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/14/61, 19 .., to 8/24/61, 19....., that (I) (we) last saw the deceased alive on 8/29 ....1961., and that death occured at 5:00 AM/PM the causes and on the date stated above.

22a. SIGNATURE: William P James M.D.

22b. DATE SIGNED: 8/30/61

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): DR. WILLIAM P. JAMES

22d. ADDRESS: 441 N. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/31/1961

23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cem.

23d. LOCATION (City, town or county) (State): Near Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Charles L. George

ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: SEP 1 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 24 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8671

CERTIFICATE OF DEATH

08665

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. A ... may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A ... this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND,
c. LENGTH OF STAY IN: 19 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 136 BEDFORD STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CHARLES; Middle: W.; Last: KEITER

4. DATE OF DEATH: Month: AUGUST; Day: 17; Year: 19 61

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN. 28, 1875

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED EMPLOYE HARVEY'S JEWELRY

10b. KIND OF BUSINESS OR INDUSTRY: STORE.

11. BIRTHPLACE (County & State, or foreign country): FREDERICK COUNTY, VA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN KEITER

14. MOTHER'S MAIDEN NAME: MARY HAMMACK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 214-05-4274

17. INFORMANT: MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND
Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Infarction, Fatal — INTERVAL BETWEEN ONSET AND DEATH: 12 days
DUE TO (b): Cerebral Sclerosis — 6 yrs
DUE TO (c): Arteriosclerosis — 5 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. / Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 19..., to A.M. ...8/17..., 19 61, that (I) (we) last saw the deceased alive on ...8/16...19 61 and that death occured at 2:40 from the causes and on the date stated above.

22a. SIGNATURE: [signature]
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/17/61

22c. PHYSICIAN'S NAME (Type): DR. DOERNER

22d. ADDRESS: WASHINGTON & CUMBERLAND STREETS, CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 8/19/61
23c. NAME OF CEMETERY OR CREMATORY: SUNSET MEMORIAL PARK
23d. LOCATION (City, town or county): CUMBERLAND (State): MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: RUTH E. SILCOX
ADDRESS: CUMBERLAND MARYLAND

25a. REC'D BY REGISTRAR DATE: AUG 21 '61
25b. REGISTRAR'S SIGNATURE: [signature]
AUG 21 '61
Arthur L. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8672

CERTIFICATE OF DEATH

Reg. Dist. No. 08666

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 14 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: 152 West Main
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMA Middle S. Last KELLER

4. DATE OF DEATH: Month 8 Day 19 Year 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-7-1886

9. AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress (retired)

10b. KIND OF BUSINESS OR INDUSTRY: Alteration Dept. Store

11. BIRTHPLACE (State or foreign country): Eckhart

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John R. Kellar

14. MOTHER'S MAIDEN NAME: Anna Kocsis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 214-05-8315

INFORMANT: Harold Dudley, Address: Frostburg, Md. 117 West Mechanic St.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hour
DUE TO (b): Arteri-Sclerotic Heart disease — 5-6 yrs.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cardiac Hypertrophy.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-9, 1961, to 8-19, 1961, that I last saw the deceased alive on 8-19, 1961, and that death occurred at 6:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H.C. Diehl M.D. ADDRESS (Street, city or town, state): 39 W. Main St. DATE SIGNED: 8/22/61

PHYSICIAN'S NAME (Type): H.C. DIEHL, M.D. Frostburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-22-61
22c. NAME OF CEMETERY OR CREMATORY: Luthern Cemetery
22d. LOCATION (City, town or county): Frostburg (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Burdette H. Monteath ADDRESS: HAFER FUNERAL HOME 123 E. Main, Frostburg, Md.

24a. REC'D BY REGISTRAR DATE: AUG 24 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2673 **CERTIFICATE OF DEATH** 08667

Item 9 Film C294 9/5/61 mn

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: MARYLAND Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 14 West Main

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: 14 West Main, Frostburg
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROY Middle VINCENT Last LARGENT

4. DATE OF DEATH: Month 8/26/61 Day Year 19

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-29-1886

9. AGE (In years last birthday): 74 75 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner (retired)

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines

11. BIRTHPLACE (County & State, or foreign country): Frostburg

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Arthur Largent

14. MOTHER'S MAIDEN NAME: Anna Llewellyn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: 191-01-0193 Mrs. Roy V. Largent, 14West Main, Address Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): [illegible] Coronary

DUE TO: 008X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): ___

DUE TO (c): ___

INTERVAL BETWEEN ONSET AND DEATH: ?? ___

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): X

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year: X 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): X

20f. (City or town) (County) (State): X

21. **I certify** that (I) (this hospital) attended the deceased from 8/16/61, 19 61, to 8/26/61, 19 61, that (I) (we) last saw the deceased alive on 8/26/61 19 61, and that death occured at 5 M, from the causes and on the date stated above.

22a. SIGNATURE: [illegible] M.D.

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/29/61

22c. PHYSICIAN'S NAME (Type): [illegible]

22d. ADDRESS: [illegible]

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/30/61

23c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park

23d. LOCATION (City, town or county): Frostburg (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Beulah H. Montesant ADDRESS: Hafer Funeral Home 23 E. Main, Frostburg, Md.

25a. REC'D BY REGISTRAR DATE: SEP 1 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8674 **CERTIFICATE OF DEATH** 08668

Items 7 & 14 Film G293 8/22/61 mh

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 29days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 104 N. Mechanic St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John Middle: Henry Last: Lindsay

4. DATE OF DEATH: Month: August Day: 14 Year: 19 61

5. SEX: male
6. COLOR OR RACE: colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-3-1880
9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Bill Lindsay
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Sacred Heart Hosp. Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Probale Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Post-Operative Recovery Period for Carcinoma of Esophagus.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 20, 19 61 to August 14, 19 61, that (I) (we) last saw the deceased alive on August 14, 19 61, and that death occured at 3:48 P.M. from the causes and on the date stated above.

22a SIGNATURE: Tahir Y. Hadidian M.D.
ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/17/61
23c. NAME OF CEMETERY OR CREMATORY: Allegany County Cem.
23d. LOCATION (City, town or county) (State): Cumb. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc.
ADDRESS: Cumb. Md
25a. REC'D BY REGISTRAR DATE AUG 18 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8675 **CERTIFICATE OF DEATH** 08669

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/60

1. **PLACE OF DEATH**
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt. 1, Frostburg
c. LENGTH OF STAY IN this place: MARYLAND 9 Months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Vale Summit
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First Stanley Middle R. Last Loar

4. **DATE OF DEATH**: Month August Day 24th, Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 2nd, 1878

9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.-Blacksmith

10b. KIND OF BUSINESS OR INDUSTRY: F'bg. Fuel Co.

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Elijah Loar

14. MOTHER'S MAIDEN NAME: Emily Morgan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 214-01-6660

17. INFORMANT: McKee Loar

Address: Rt. 3, Frostburg, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of stomach — INTERVAL BETWEEN ONSET AND DEATH: 1 1/2 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive Cardio-

DUE TO (c): Vascular disease — 5-6 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 8-18, 1961, to 8-24, 1961, that (I) (~~saw~~) last saw the deceased alive on 8-24 1961, and that death occured at 10:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: H. C. Diehl,

M.D.

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/25/61

22c. PHYSICIAN'S NAME (Type): H. C. Diehl,

22d. ADDRESS: 39 W. Main St., Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-27-61

23c. NAME OF CEMETERY OR CREMATORY: M.E. Cemetery

23d. LOCATION (City, town or county) (State): Vale Summit, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: L. P. Durst

ADDRESS: Frostburg, Md.

25a. REC'D BY REGISTRAR DATE: AUG 29 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Keaus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8676 — 08670

R___ Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 44 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 947 MARYLAND AVE.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle W. — Last MARTIN
4. DATE OF DEATH: Month AUGUST — Day 4 — Year 1961

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: APRIL 6, 1912
9. AGE (In years last birthday): 49 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist Helper
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): MARYLAND-LITTLE ORLEANS
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EDWARD R. MARTIN
14. MOTHER'S MAIDEN NAME: CHRISTINA SMITH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 705-12-4957
17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CARCINOMA OF ADRENAL WITH METASTASIS — INTERVAL BETWEEN ONSET AND DEATH: MONTHS

195.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY — Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — DATE SIGNED
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
DEPUTY MEDICAL EXAMINER ☒ AUGUST 6, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 7, 1961
22c. NAME OF CEMETERY OR CREMATORY: Martin Cemetery
22d. LOCATION (City, town, or county) (State): Little Orleans, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli, Cumberland, Md.
24a. REC'D BY REGISTRAR — DATE: AUG 10 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8677 **CERTIFICATE OF DEATH** 08671

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL CRESAPTOWN
d. STREET ADDRESS: 629 MC MULLAN HIGHWAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First CHARLES — Middle J — Last MC DONALD

4. **DATE OF DEATH**: Month 8 — Day 2 — Year 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 14, 1893

9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Celanese

10b. KIND OF BUSINESS OR INDUSTRY: Textiles

11. BIRTHPLACE (County & State, or foreign country): Franklin, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Mc Donald

14. MOTHER'S MAIDEN NAME: Annie Faller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 055-07-1176

17. INFORMANT: Charles J. McDonald, Jr. — Address: Bowling Green Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary and Hypertensive Cardio-vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 8 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3-19-19[illegible] to 8-2-19 61 that (I) (we) last saw the deceased alive on 8-2-19 61 and that death occured at 9p.M, from the causes and on the date stated above.

22a. SIGNATURE: Ralph W. Ballin M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 8-3-61

22c. PHYSICIAN'S NAME (Type): Ralph W. Ballin, M.D.

22d. ADDRESS: 62 Greene St. Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: Aug. 5, 1961 — 23c. NAME OF CEMETERY OR CREMATORY: St. Ambrose Cemetery — 23d. LOCATION (City, town or county) (State): Cresaptown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Harry L. Ziegler — ADDRESS: Hyndman, Pa.

25a. REC'D BY REGISTRAR DATE: AUG 7 '61

25b. REGISTRAR'S SIGNATURE: Cullen L. Knaus

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8678 **CERTIFICATE OF DEATH** 08672

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

I

1. **PLACE OF DEATH** a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 14 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg,
d. STREET ADDRESS: 7 S. Water Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Ernest — Middle: B. — Last: McKenzie

4. **DATE OF DEATH**: Month: August — Day: 3rd, — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb.19th,1895

9. AGE (If years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret-Engineering Dept.

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John F. McKenzie

14. MOTHER'S MAIDEN NAME: Annie Loar

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): W.W.1

16. SOCIAL SECURITY NO.: 213-09-6378

17. INFORMANT: Address: Mrs.Eva B.McKenzie,7 S.Water St.F'bg.Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a) (b) and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Encephalitis — INTERVAL BETWEEN ONSET AND DEATH: 2 Days
DUE TO (b): Bronko Pneumonia — 15 Days
DUE TO (c): Bronchial Asthma — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 19 1961, to Aug 3 ..., 1961, that (I) (we) last saw the deceased alive on Aug 3 ... 1961, and that death occurred at 9.05 AM, from the causes and on the date stated above.

22a. SIGNATURE: W O McLane M.D

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: Aug 4 1961

22c. PHYSICIAN'S NAME (Type): W. O. McLane,

22d. ADDRESS: 167 E. Main St.,Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-5-61

23c. NAME OF CEMETERY OR CREMATORY: F'bg.Memorial Park

23d. LOCATION (City, town or county) (State): Frostburg, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: L. P. Durst

ADDRESS: Frostburg, Md.

25a. REC'D BY REGISTRAR DATE: AUG 7 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8679 08673

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After the certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) TSM 9/59

1. PLACE OF DEATH — a. COUNTY: ALLEGANY — MARYLAND; b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG*RF.D. #1; c. LENGTH OF STAY IN 1b:

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) — a. STATE: MARYLAND; b. COUNTY: ALLEGANY; c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): FROSTBURG- R.F.D. # 1; d. STREET ADDRESS:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle H. Last MILLER

4. DATE OF DEATH: Month AUGEST Day 10 Year 1961

5 SEX	6 COLOR OR RACE	7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS: Hours	Min.
MALE	WHITE		JAN. 1, 1888	73 yrs				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
RETIRED MINNER	COAL MINE	GILMORE	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
GEORGE MILLER	VICTORIA BUSKIRK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
YES *WORLD WAR 1	220-10-2722	MRS. CHARLES BUCKINGHAM (DAUGHTER), HAGERSTOWN, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) +42× Hypertensive Cardio-Vascular disease.

DUE TO (b)

Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 5-6 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic bronchitis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 10, 1961, to Aug. 10, 1961, that (I) (~~not~~) last saw the deceased alive on Aug. 7 1961, and that death occurred at 11 A.M. from the causes and on the date stated above.

22a SIGNATURE H. C. Diehl, M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐ 22b DATE SIGNED 8/11/61

22c PHYS.CIAN'S NAME (Type) H.C. DIEHL, M.D. 22d. ADDRESS Frostburg, Md.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City, town, or county) (State)
BURIAL	AUG. 14, 61	MEMORIAL PARK	FROSTBURG, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
GEORGE EICHHORN, LONACONING, MARYLAND	AUG 14 '61	Arthur L. Kuhn

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8680 — 08674

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pe[illegible] may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A[illegible] is certificate has been signed by the attending physician and completely [illegible] in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERL ND
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 501 N. MECHANIC ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FLOYD; Middle OSCAR; Last MOORE
4. DATE OF DEATH: Month AUGUST; Day 13; Year 1961
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: MARCH 24, 1883
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman For Cumberland Contracting Co
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City, State, or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JOHN MOORE (DECEASED)
14. MOTHER'S MAIDEN NAME: MARY HIGGINS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: 218-34-4632
17. INFORMANT: OLD CHART
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral - Hemorrhage
331X
DUE TO (b): Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/7, 1961, to 8/13, 1961, that (I) (we) last saw the deceased alive on 8/12, 1961, and that death occured at 1:55 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Leo H. Ley Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/14/61
22c. PHYSICIAN'S NAME (Type): LEO H. LEY, JR., M.D.
22d. ADDRESS: 456 N. CENTER ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: AUG 15, 1961
23c. NAME OF CEMETERY OR CREMATORY: SUNSET MEMORIAL PARK
23d. LOCATION (City, town or county) (State): CUMBERLAND MARYLAND

24 FUNERAL DIRECTOR'S SIGNATURE: RUTH E. SILCOX
ADDRESS: CUMBERLAND MARYLAND

25a. REC'D BY REGISTRAR DATE: AUG 16 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8681

CERTIFICATE OF DEATH

Items 3 & 13 Film 18675

Item 14 Film G293 8/28/61 iwk G293 8/29/61

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 7/7/1961
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Luke
d. STREET ADDRESS: West Vaco Club, Mullen Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Joseph — Middle — Last Nagy ~~Gnagey~~

4. DATE OF DEATH: Month August — Day 23, — Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10/16/1876
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired; Gardener
10b. KIND OF BUSINESS OR INDUSTRY: Gardener
11. BIRTHPLACE (State or foreign country): Hungary
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13 FATHER'S NAME: John ~~Gnagey~~ Nagy
14. MOTHER'S MAIDEN NAME: Veronica unknown

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: P.O.Box 599, Allegany County Infirmary records. Address Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocarditis, Senile degeneration — INTERVAL BETWEEN ONSET AND DEATH
422.1
DUE TO
(b) Arteriosclerosis, Senile.
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Hour o. m. p. m Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 7/7/61, 19__, to 8/23/61, 19__, that (I) (we) last saw the deceased alive on 8/22/61 19__, @ 1:00 A M, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: L. Mathews M.D
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 8/23/61
22c. PHYSICIAN'S NAME (Type): Dr. Lee B. Mathews
22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 8/25/61
23c NAME OF CEMETERY OR CREMATORY: St. Peters Cem.
23d LOCATION (City, town, or county) (State): Westernport Md.

24 FUNERAL DIRECTOR'S SIGNATURE: E. L. Burd
ADDRESS: Westernport, Md.
25a REC'D BY REGISTRAR DATE AUG 25 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4) 15M 9/59

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8682 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 08676

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please so advise the certificate, by the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15M8 5M 8/60

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: MARYLAND LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 515 FURNACE STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNA Middle MARY Last O'BAKER
4. DATE OF DEATH: Month AUG. Day 31 Year 19 61
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC. 3, 1881
9. AGE (In years last birthday): 79 yrs. IF UNDER 1 YEAR: Months, Days IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: AUGUST MACKERT
14. MOTHER'S MAIDEN NAME: CATHERINE GRELLER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: LAWRENCE O'BAKER Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): CORONARY SCLEROSIS

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: AUGUST 31, 1961
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
Address (Street, city, town, or county): CUMBERLAND, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: SEPT. 4, 1961
22c. NAME OF CEMETERY OR CREMATORY: ST. PATRICKS CEMETERY
22d. LOCATION (City, town, or country) (State): CUMBERLAND, MD.

23. FUNERAL DIRECTOR: BYRON KIGHT ADDRESS: CUMBERLAND, MD.
24a. REC'D BY REGISTRAR DATE: SEP 5 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8683 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08677

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files or to burial, cremation, or removal.

TO FUNERAL DIRECTOR: Page 4 should be used as a burial-transit permit. File pages 1 and 2 with registrar.

1. PLACE OF DEATH
   a. COUNTY: Allegany — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
   c. LENGTH OF STAY IN 1b: Minutes
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
   a. STATE: West Virginia — b. COUNTY: Mineral
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wiley Ford
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARA — Middle LARUE — Last PEER

4. DATE OF DEATH: Month August — Day 11, — Year 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 13, 1898

9. AGE (If years last birthday): 63 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Edinburg, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Beddows

14. MOTHER'S MAIDEN NAME: Elnora Marshall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
   (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mrs Gilbert Garlitz, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): PULMONARY EDEMA; ACUTE MYOCARDIAL FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 1 Hour

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): CORONARY ARTERY DISEASE

DUE TO (c): CORONARY SCLEROSIS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skiturelic M.D.

EXAMINER'S NAME (Type): Benedict Skiturelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: August 12, 1961
Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: August 14, 1961

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: AUG 16 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kuhn

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8684 **CERTIFICATE OF DEATH** 018678

1. **PLACE OF DEATH**
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
c. LENGTH OF STAY IN 1b: 19 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 420 AVIRETT AVENUE
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle JEANETTE Last PHILLIPS

4. DATE OF DEATH: Month AUGUST Day 4, Year 19 61

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-22-1901

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): W. VA.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: REV. CHARLES J. PRICE

14. MOTHER'S MAIDEN NAME: ANNA V. HALL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 334X
DUE TO (b): Hemiplegia
DUE TO (c): Cerebral arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 1 month 1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 9, 19 61 to August 4 19 61, that (I) (we) last saw the deceased alive on August 4, 19 61, and that death occured at 2:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: B. M. Schindler M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/9/61

22c. PHYSICIAN'S NAME (Type): DR. BLANE SCHINDLER

22d. ADDRESS: 43 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 7, 1961

23c. NAME OF CEMETERY OR CREMATORY: Hill Crest Burial Park

23d. LOCATION (City, town or county) (State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Byron Kight Cumberland, Md.

25a. REC'D BY REGISTRAR DATE AUG 10 '61

25b. REGISTRAR'S SIGNATURE: Esther L. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any item is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8685 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08679

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pinto near Cresaptown
c. LENGTH OF STAY IN 1b: MARYLAND 17 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): On farm of J.T. Mason

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pinto near Cresaptown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First ROBERT Middle J. Last POLING

4. DATE OF DEATH: Month August Day 3 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] **NEVER MARRIED** [X] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: Dec. 7, 1943

9. AGE (If years last birthday): 17 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Dairy Farm

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: William Poling

14. MOTHER'S MAIDEN NAME: Rose Dawson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO. (If yes give war or dates of service):

17. INFORMANT Address: Mrs. Harry Albright, Pinto near Cresaptown, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	ASPHYXIATION; TRAUMATIC	5-10 Min.
DUE TO (b)	COMPRESSION OF CHEST	5-10 Min.
DUE TO (c)	PINNED UNDER OVERTURNED FARM TRACTOR	5-10 Min

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Farm tractor overturned pinning deceased under it.

20c. TIME OF INJURY Hour a.m. 5:00 Month, Day, Year Aug. 3 1961

20d. INJURY OCCURRED While at work [X] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Farm

20f. (City or town): Pinto (County): Alleg. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

Address (Street, city town, or county): Cumberland, Md. (State)

DATE SIGNED: August 3, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: August 6, 1961

22c. NAME OF CEMETERY OR CREMATORY: Zion ~~Prais~~ Memorial Cem.

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR ADDRESS: John J. Hafer, Cumberland, Maryland

24c. REC'D BY REGISTRAR DATE: AUG 8 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8685 — 8868(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: MARYLAND — 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RT. 4, CUMBERLAND
d. STREET ADDRESS: North Branch
e. IS RESIDENCE ON A FARM? YES XX NO

3. NAME OF DECEASED (Type or print): First JOSEPH — Middle WASHINGTON — Last POLLOCK

4. DATE OF DEATH: Month AUGUST — Day 29, — Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED X — NEVER MARRIED — WIDOWED — DIVORCED

8. DATE OF BIRTH: 1-22-1890

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (County & State, or foreign country): Allegany, Md.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: ROBERT POLLOCK

14. MOTHER'S MAIDEN NAME: EMMA GRACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO: 215-20-6496

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ~~sic~~ X
DUE TO (b): Cerebral Hemorrhage
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH: 2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES — NO X

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour e.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 8-28-, 1961 to 8-29-, 1961 that (I) ~~(we)~~ last saw the deceased alive on 8-29-, 1961 and that death occurred at 8:55 P.M. from the causes and on the date stated above.

22a. SIGNATURE: W. F. Williams M.D.

ATTENDING PHYS. X — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DR. W. F. WILLIAMS

22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/1/61

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

23d. LOCATION (City, town or county) (State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: H. Wayne George, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE SEP 5 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Rinna

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8687

CERTIFICATE OF DEATH

08681

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: PENNSYLVANIA
b. COUNTY: SOMERSET
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MEYERSDALE
d. STREET ADDRESS: RT. #4.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: GEORGE — Middle: WILLIAM — Last: PORTER

4. DATE OF DEATH: Month: AUGUST — Day: 8 — Year: 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: NOVEMBER 10, 1902

9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): MT. SAVAGE, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE G. PORTER

14. MOTHER'S MAIDEN NAME: TILLIE KENNELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT: MEMORIAL HOSPITAL, CUMBERLAND, MD. — Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral metastases — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

DUE TO (b): Carcinoma of Prostate — 18 mos

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from January 1960 to 8 Aug., 1961, that (I) (we) last saw the deceased alive on 8 Aug. 1961, and that death occured at 11:10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: James G. Stegmaier M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9 Aug. 61

22c. PHYSICIAN'S NAME (Type): JAMES G. STEGMAIER

22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug.12,1961

23c. NAME OF CEMETERY OR CREMATORY: Temple EUB Cemetery

23d. LOCATION (City, town or county) (State): Meyersdale,Pa. RD#4

24. FUNERAL DIRECTOR'S SIGNATURE: Harvey H. Feigley

ADDRESS: Hyndman,Pa.

25a. REC'D BY REGISTRAR DATE: AUG 14 '61

25b. REGISTRAR'S SIGNATURE: Clinton S. Kuns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8688 — 08682

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 22 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LONACONING
d. STREET ADDRESS: 18 CASTLE HILL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle M. — Last RALSTON

4. DATE OF DEATH: Month AUGUST — Day 9, — Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 12-3-1893

9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: TIRE CO. KELLY SPRINGFIELD

11. BIRTHPLACE (County & State, or foreign country): LONACONING, MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: HENRY RALSTON

14. MOTHER'S MAIDEN NAME: MARGARET BARCLAY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wars or dates of service):

16. SOCIAL SECURITY NO.: 214-05-9619

17. INFORMANT: Address: WARWICK & MEMORIAL AVENUE — MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Metastasis carcinoma of liver	
DUE TO	(b) Carcinoma of large bowel	?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO	(c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/11, 1961 to 8/9, 1961, that (I) (we) last saw the deceased alive on 8/8 1961, and that death occured at 4:10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Samuel Jacobson M.D.

22b. DATE SIGNED: 8/9/61

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): DR. SAMUEL JACOBSON

22d. ADDRESS: 50 PERSHING STREET, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/11/1961

23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery

23d. LOCATION (City, town or county) (State): Lonaconing, MD.

24 FUNERAL DIRECTOR'S SIGNATURE: GEORGE EICHHORN

ADDRESS: LONACONING? MD.

25a. REC'D BY REGISTRAR DATE AUG 14 '61

25b. REGISTRAR'S SIGNATURE: Arthur J. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: When this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3689

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08683

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 29 Hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital--Cumberland,Md.

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: W.VA.
b. COUNTY: MINERAL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Keyser
d. STREET ADDRESS: 284 Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: IRA — Middle: L. — Last: RAVENSCROFT

4. DATE OF DEATH: Month: Aug. — Day: 27 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARR.ED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June.19,1894

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months: 2 — Days: 8
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carman

10b. KIND OF BUSINESS OR INDUSTRY: B.& O.Railroad

11. BIRTHPLACE (State or foreign country): McCoole Twenty-first Bridge,Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Ravenscroft

14. MOTHER'S MAIDEN NAME: Lidia Ravenscroft

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 705-09-7135

17. INFORMANT: Memorial Hospital--Cumberland, Md. — Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Thoracic Hemorrhage, bilateral — INTERVAL BETWEEN ONSET AND DEATH: 29 Hrs.

DUE TO (b): Crushed Chest; Ruptured Right Lung — 29 Hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Passenger in an Automobile Accident

20c. TIME OF INJURY — Hour e.m.: 11:50 — Month, Day, Year: Aug.26 1961

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rt.220 South of Rawlings, Alleg. Md.

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: AUGUST 27,1961

Address (Street, city, town, or county): Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-30-61

22c. NAME OF CEMETERY OR CREMATORY: Meadow Point Cemetery

22d. LOCATION (City, town, or country) (State): Keyser,W.Va.

23. FUNERAL DIRECTOR: Markwood Fun. Home — ADDRESS: Keyser W.Va.

24a. REC'D BY REGISTRAR DATE: AUG 31 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEFER MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8690 08684

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
c. LENGTH OF STAY IN 1b: 21 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
d. STREET ADDRESS: 702 MARYLAND AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First REAZON Middle ALONZO Last RUCKMAN

4. DATE OF DEATH: Month AUGUST Day 3 Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-10-1883

9. AGE (In years last birthday): 78 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carpentar

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (County & State, or foreign country): W.VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THOMAS LEE RUCKMAN

14. MOTHER'S MAIDEN NAME: ZELENA HAINES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 171-10-9246

17. INFORMANT: Mrs. Reazon Ruckman Address: Cumberland, Md. 702 Maryland Ave.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia Bronchial
DUE TO (b): ASCVD.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Congestive Heart Failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from July 13, 1961, to AUG. 3, 1961, that ☐ (we) last saw the deceased alive on Aug 3 1961, and that death occured at 8:10 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Walter N. Mimmler M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/5/61

22c. PHYSICIAN'S NAME (Type): DR. WALTER N. MIMMLER

22d. ADDRESS: 412 NORTH MECHANIC ST., CUMBERLAND, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial 8/6/61

23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery

23d. LOCATION (City, town or county) (State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: H. Wayne George, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: AUG 8 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kress

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Personal data may be furnished by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8691

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08685

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 10 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELLERSLIE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROY Middle EMORY Last SHAFFER

4. DATE OF DEATH: Month AUGUST Day 5, Year 19 61

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-12-36

9. AGE (In years last birthday): 25 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bartender

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nevin Araig Shaffer

14. MOTHER'S MAIDEN NAME: Flossie Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes, give wer or dates of service): Yes 1954-57

16. SOCIAL SECURITY NO.: 219-34-6040

17. INFORMANT: CH ART
Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): INTRACRANIAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 40 Min.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): SKULL FRACTURE — 40 Min.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Automobile Accident

20c. TIME OF INJURY Hour e.m. 1:15 Month, Day, Year Aug. 5 19 61

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 96 near

20f. (City or town) Springtown, (County) Bedford, (State) Pa.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): Cumberland, Md. (State)

DATE SIGNED: August 5, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 8, 1961

22c. NAME OF CEMETERY OR CREMATORY: Porter Cemetery

22d. LOCATION (City, town, or country) (State): Hyndman, Pa. RD#1

23. FUNERAL DIRECTOR: Harvey A. Feigley

ADDRESS: Hyndman, Pa.

24c. REC'D BY REGISTRAR DATE: AUG 8 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the items is necessary, please explain in the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8692

CERTIFICATE OF DEATH

18686

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Westernport
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1 Mi. N. Westernport

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Md. b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Westernport
d. STREET ADDRESS: 1 Mi. N. Westernport
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elmer — Middle: Bernie — Last: Sheffler
4. DATE OF DEATH: Month: Aug. — Day: 13 — Year: 19 61

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 24, 1888
9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ware houseman
10b. KIND OF BUSINESS OR INDUSTRY: Dept. Store
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Bernie Sheffler
14. MOTHER'S MAIDEN NAME: Emily E. Hockman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of serv.ce): W.W. I
16. SOCIAL SECURITY NO.: 335-10-2220
17. INFORMANT: Mrs. Anna Sheffler — Address: Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 30 mins
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug. 13, 1961 to Aug. 13, 1961, that (I) (we) last saw the deceased alive on Aug. 13, 1961, and that death occured at 3:30 pm, from the causes and on the date stated above.

22a. SIGNATURE: William W. Lesh. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug 14, 1961
22c. PHYSICIAN'S NAME (Type): William W. Lesh
22d. ADDRESS: Westernport, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/16/61
23c. NAME OF CEMETERY OR CREMATORY: Philos
23d. LOCATION (City, town or county) (State): Westernport Md.

24 FUNERAL DIRECTOR'S SIGNATURE: E. Beal
ADDRESS: Westernport, Md.
25a. REC'D BY REGISTRAR DATE: AUG 17 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The hospital or attending physician may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: A completely executed certificate has been signed by the attending physician and is ready for filing with the local registrar. Please complete the certificate and obtain the signature of the physician as soon as the burial-transit permit is issued.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3693

CERTIFICATE OF DEATH

18687

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [illegible] may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: [illegible] this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: PENNSYLVANIA — b. COUNTY: BEDFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RT. #1, HYNDMAN
d. STREET ADDRESS: 75 x 5
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: STELLA — Middle: J. — Last: SHROYER

4. DATE OF DEATH: Month: AUGUST — Day: 31 — Year: 1961

5. SEX: FEMALE — 6. COLOR OR RACE: WHITE — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: 10-8-1890 — 9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JOHN EMERICK
14. MOTHER'S MAIDEN NAME: EMMA MARTZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Central Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 Days

DUE TO (b): Hypertensive Cardiovascular Disease

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/30, 1961, to 8/31, 1961, that (I) (we) last saw the deceased alive on ..... 19.., and that death occured at 7:50 P.M., from the causes and on the date stated above.

22a. SIGNATURE: William P. James — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): WILLIAM P. JAMES
22d. ADDRESS: 211 N. CENTRE ST. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 9/4/61
23c. NAME OF CEMETERY OR CREMATORY: Comps Cemetery
23d. LOCATION (City, town or county) (State): Hyndman, Pa. RD#1

24. FUNERAL DIRECTOR'S SIGNATURE: Harvey H. Feagler — ADDRESS: Hyndman, Pa.

25a. REC'D BY REGISTRAR DATE: SEP 6 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8694

CERTIFICATE OF DEATH

08688

1

M

I

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MARYLAND
c. LENGTH OF STAY IN: MARYLAND 3 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLDTOWN, MARYLAND
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HANSON Middle M Last SLIDER

4. DATE OF DEATH: Month AUGUST Day 13, Year 19 61

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10-28-1877

9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours M'n.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED MAIL CARRIER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MARYLAND Greenridge

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM SLIDER

14. MOTHER'S MAIDEN NAME: MARY E. TWIGG

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO:

17. INFORMANT Address: MEMORIAL HOSPITAL CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 331 X

DUE TO (b): Cerebro-vascular Accident

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Generalized arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH: 2 weeks / yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May, 1957 to Aug 13, 1961, that (I) (we) last saw the deceased alive on 8/13/1961, and that death occured at 1:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: George M Simons M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DR. G. SIMONS.

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-16-61

23c. NAME OF CEMETERY OR CREMATORY: Zion Memoral Cemetery

23d. LOCATION (City, town or county) (State): Cumberland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE AUG 17 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [illegible] may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A [illegible] this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in and signed by the funeral director, page 3 should be detached for the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8695

18689

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Lonaconing
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: St.Marys Terrace

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
d STREET ADDRESS: St.Marys Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Agnes — Middle: A. — Last: Smith

4. DATE OF DEATH: Month: August — Day: 11 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 22,1882

9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR IF UNDER 24 HRS — Months: — Days: — Hours: — Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Garrett County, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Weir

14. MOTHER'S MAIDEN NAME: Ann McMillian

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Sherman Hyde "Daughter" Address: Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Arteriosclerosis — years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Severe Rheumatoid Arthritis - Congestive heart failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 1956 to Aug. 11, 1961, that (I) (we) last saw the deceased alive on Aug 9 1961, and that death occurred at 5 9AM, from the causes and on the date stated above.

22a. SIGNATURE: L.R. Miles, JR. M.D — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: 8.12.61

22c. PHYSICIAN'S NAME (Type): L.R. MILES, JR., M.D.

22d. ADDRESS: Lonaconing Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 8/13/61

23c NAME OF CEMETERY OR CREMATORY: Philos Cemetery

23d. LOCATION (City, town, or county) (State): Westernport, ,Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: George Eichhorn Lonaconing, Md.

25a. REC'D BY REGISTRAR DATE: AUG 14 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kinard

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8698 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08611

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 712 Avondale Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNIE — Middle MARY — Last STEGMAIER

4. DATE OF DEATH: Month August — Day 5 — Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 18, 1876

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Detterman

14. MOTHER'S MAIDEN NAME: Barbara Lydinger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Edward L. Melvin — Address: Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — ----
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): FRACTURE OF RIGHT HIP

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): FELL OUT OF BED AT HOME

20c. TIME OF INJURY Month, Day, Year: 4:00 Hour o. m. p. m. AUG. 2 1961

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): HOME

20f. (City or town) (County) (State): CUMBERLAND, ALLEG. MD.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: AUGUST 5, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 8, 1961
22c. NAME OF CEMETERY OR CREMATORY: SS Peter & Paul Cemetery
22d LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Steinbrecher — ADDRESS: 117 Frederick St. Cumb. Md.
24a. REC'D BY REGISTRAR DATE: AUG 9 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 4 should be used as a burial-transit permit. File pages 1 and 2 with registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3697 **CERTIFICATE OF DEATH** 18691

1

M

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 28 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 114 EAST OLDTOWN ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROSE — Middle CATHERINE — Last THUSS

4. DATE OF DEATH: Month AUGUST — Day 25 — Year 19 61

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 11-29-83

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE, Seamstress Self Emp.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): MARYLAND Cumberland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

I

13. FATHER'S NAME: CHARLES MCDERMOTT

14. MOTHER'S MAIDEN NAME: Annie Walters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: 214-05-4088

17. INFORMANT: CHART — Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Anemia — INTERVAL BETWEEN ONSET AND DEATH: Yrs

DUE TO (b): Cerebral Thrombosis — 3 wks

DUE TO (c): Arteriosclerosis — 5 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332.4

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 25, 19 61, to Aug 25, 19 61, that (I) (we) last saw the deceased alive on Aug 24 19 61, and that death occured at 5:25 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Clay Durrett M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Clay Durrett, M.D.

22d. ADDRESS: 236 Virginia Avenue

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 8-28-61 — 23c. NAME OF CEMETERY OR CREMATORY: St. Marys Cem. — 23d. LOCATION (City, town or county) (State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli Cumberland, Md.

25a. REC'D BY REGISTRAR DATE SEP 1 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Personal data may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A permit for burial or removal may not be issued by the registrar of vital statistics for use as the burial-transit permit. This certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH
869S DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
18692

M

I

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 2/26/1961
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 1200 Holland Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Ida Middle: Blanch Last: Triplett
4. DATE OF DEATH: Month: August Day: 22, Year: 1961

5 SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 2/20/1872
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Kerns, West Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Elom Daniels
14. MOTHER'S MAIDEN NAME: Luisa Wilmoth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT P.O.Box 599 Address Cumberland, Md.
Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Hypocondilis, Chronic degeneration
DUE TO (b): Arterio-Sclerosis, Senile.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 2/26/61, 19___ to 8/22/61, 19___, that (I) (we) last saw the deceased alive on 8/22/61 19___ @ 10:20 A.M., and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: L. Mathews M.D
ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒
22b DATE SIGNED: 8/23/61
22c PHYSICIAN'S NAME (Type): Dr. Lee B. Mathews
22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/25/61
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cem.
23d LOCATION (City, town, or county) (State): Cumberland Md

24. FUNERAL DIRECTOR'S SIGNATURE: John J Hafer ADDRESS: Cumberland Md
25a REC'D BY REGISTRAR DATE AUG 28 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in and signed by the funeral director, page 3 should be detached for issuance of the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and they should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8693 08693

1 (M) I

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 27 HRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL CUMBERLAND
d. STREET ADDRESS: Route #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First IDA Middle V. Last TURNER

4. DATE OF DEATH: Month AUGUST Day 11, Year 1961

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec 25,1883

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (County & State, or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MARTIN KEPLINGER

14. MOTHER'S MAIDEN NAME: AMELIA FEASTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT'S Address: CHART

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 2 6 C X
DUE TO (b): Cerebral Thrombosis
DUE TO (c): Generalized arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Years ____ Months ____ Days ____ Hours ____ Min. ____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from August 9, 1961 to August 11, 1961 that (I) (we) last saw the deceased alive on August 11, 1961, and that death occured at 12:55 AM, from the causes and on the date stated above.

22a. SIGNATURE: B. M. Schindler

22b. DATE SIGNED: 8-11-61

22c. PHYSICIAN'S NAME (Type): Bland M. Schindler M.D.

M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: 43 Green St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: AUGUST 13,61

23c. NAME OF CEMETERY OR CREMATORY: GLENDALE CEMETERY

23d. LOCATION (City, town or county): FLINTSTONE (State): MARYLAND

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: RUTH E. SILCOX CUMBERLAND MARYLAND

25a. REC'D BY REGISTRAR DATE: AUG 15 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8700

CERTIFICATE OF DEATH

10694

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La VALE
c. LENGTH OF STAY IN 1b: 50 YEARS
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: 139 NATIONAL HIGHWAY

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X La VALE
d STREET ADDRESS: 139 NATIONAL HIGHWAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET Middle E. Last WAGNER

4. DATE OF DEATH: Month AUG. Day 9, Year 19 61

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JUNE 9,1878

9 AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: PATRICK SHERRY

14. MOTHER'S MAIDEN NAME: MARGARET BINNIX

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17 INFORMANT Address: MRS. JAMES WILLETTS, LaVALE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 3 years

42-1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 3-26 1958 to 8-9 1961, that (I) (we) last saw the deceased alive on 8-7 19 61 and that death occurred at 9a M, from the causes and on the date stated above

22a. SIGNATURE: Ralph V. Ballin M.D.

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED

22c PHYSICIAN'S NAME (Type): Ralph V. Ballin, M.D.

22d ADDRESS: 62 Greene St. Cumberland, Md. 8-9-61

23a. BURIAL, CREMATION REMOVAL (Specify): BURIAL

23b. DATE THEREOF: AUG. 11,1961

23c NAME OF CEMETERY OR CREMATORY: FROSTBURG MEMORIAL PARK

23d LOCATION (City, town, or county): FROSTBURG, Md. (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: BYRON KIGHT

ADDRESS: CUMBERLAND, MD.

25a. REC'D BY REGISTRAR DATE AUG 14 '61

25b REGISTRAR'S SIGNATURE: Cathryn S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 7SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8701

CERTIFICATE OF DEATH

08695

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 1300 LEXINGTON AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JOHN — Middle: HENRY — Last: WHITACRE

4. DATE OF DEATH: Month: AUGUST — Day: 10 — Year: 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JULY 14 1876

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (County & State, or foreign country): W.VA. OKONOKO

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN WHITACRE

14. MOTHER'S MAIDEN NAME: MARY SIRBAUGH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Mrs. John Armentrout — Address: 1300 Lexington Ave Cumb. Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 1. Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.
DUE TO (b): Hemorrhaged Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1.a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.) — 20f. (City or town) — (County) Cumb. — (State) Md.

21 **I certify** that (I) (this hospital) attended the deceased from 4/7/61, 19..., to 8/10/61, 19..., that (I) ~~(we)~~ last saw the deceased alive on 8/10/61 19, and that death occurred 12:10 PM from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

22b. DATE SIGNED: 8/11/61

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): R.J.WILLIAMS

22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/13/61

23c. NAME OF CEMETERY OR CREMATORY: Abe. Cemetery

23d. LOCATION (City, town or county) (State): Near Ridgeley, W. Va.

24 FUNERAL DIRECTOR'S SIGNATURE: Charles L. George

ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: AUG 14 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Items 1 to 24 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8702

CERTIFICATE OF DEATH

08696

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Midland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Midland
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle DEWEY Last WILLIAMS

4. DATE OF DEATH: Month 8/8/1961 Day Year 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/23/1898

9. AGE (In years last birthday): 62 yrs

IF UNDER 1 YEAR: Months / Days / Hours / Min.
IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): State Road Engineer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ocean , MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Williams

14. MOTHER'S MAIDEN NAME: Elizabeth Walters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 214-07-1517

17. INFORMANT: Mr. James E. Williams, Midland, MD. (SON)
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 20 min.
DUE TO (b): Coronary Sclerosis — 7
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Aug 8, 1961, to Aug 8, 1961, that (I) (we) last saw the deceased alive on June 30, 1961, and that death occurred at 4:40 A. from the causes and an the date stated abave.

22a SIGNATURE: W O'M Page M.D

ATTENDING PHYS. ☐ MED DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: Aug 8 1961

22c PHYSICIAN'S NAME (Type): W O'M Page M D

22d. ADDRESS: Frostburg Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/10/1961

23c. NAME OF CEMETERY OR CREMATORY: Memorial Park

23d. LOCATION (City, town, or county) (State): Frostburg, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: GEORGE EICHHORN

ADDRESS: LONACONING, MD.

25a. REC'D BY REGISTRAR DATE AUG 11 '61

25b REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed as to items on page 1 and 2 should be filed with the funeral director, page 3 should be detached for filing as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8703

CERTIFICATE OF DEATH

Item 5 Film G296 8/28/61 iwk

11869

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please complete items 1 to 24 and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 320 SCHLEY STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
WILBUR	B. V.	WILSON	AUGUST	20,	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE		SEPT. 3, 1883	77 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Attorney	Law	PAW PAW, W. VA.	U. S. A.

13. FATHER'S NAME: OLIVER WILSON
14. MOTHER'S MAIDEN NAME: Emma Fisher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	acute left ventrcular failure	instant
420.1 DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	acute posterior myocardial infarction	24 hrs.
DUE TO (c)	myocardial fibrosis — coronary arteriosclerosis	?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from January 30, 1961 to August 20, 1961, that (I) (we) last saw the deceased alive on August 19, 1961, and that death occured at 9:00AM from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): DR. SAMUEL M. JACOBSON
22d. ADDRESS: 50 PERSHING ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	8/23/61	Rose Hill Cem.	Cumberland, Md

24 FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc - Cumb. Md
ADDRESS
25a. REC'D BY REGISTRAR DATE AUG 23 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8704

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland — c. LENGTH OF STAY IN 1b: 7/25/1961	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 43 Westernport
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary	d. STREET ADDRESS: 114 Wood Street — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First: Jacob — Middle: L. — Last: Wilt	4. DATE OF DEATH: Month: August — Day: 20, — Year: 1961
5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 7/30/1896 — 9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired: Railroad Engineer — 10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Bond, Maryland — 12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: James Alexander Wilt	14. MOTHER'S MAIDEN NAME: Sarah Frances Foutz
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO — 16. SOCIAL SECURITY NO.	17. INFORMANT: P.O.Box 599 Address: Cumberland, Md. Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hypocardilis, Abs. Senile — 422.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Arteriosclerosis, Senile

DUE TO

(c): Cerebral apoplexy, left Hemiplegia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	

21. I **certify** that (I) (this hospital) attended the deceased from 7/25/61, 19__ to 8/20/61, 19__, that (I) (we) last saw the deceased alive on 8/19/61, 19__, @ 6:50 P.M., and that death occurred at __M. from the causes and on the date stated above.

22a. SIGNATURE: Lee B. Mathews M.D.	ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒	22b. DATE SIGNED: 8/21/61	
22c. PHYSICIAN'S NAME (Type): Dr. Lee B. Mathews	22d. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 8/23/61	23c. NAME OF CEMETERY OR CREMATORY: Philos Cem.	23d. LOCATION (City, town, or county): Westernport	(State): Md.
24. FUNERAL DIRECTOR'S SIGNATURE: E. S. Beal	ADDRESS: Westernport, Md.	25a. REC'D BY REGISTRAR DATE: AUG 23 '61	25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59